State of California
Department of Health Services

California Department of Health Services
DIANA M. BONTÁ, R.N., DR P.H.
Director

GRAY DAVIS
Governor

July 18, 2003

CCS Information Notice No.: 03-13

TO: ALL CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM INDEPENDENT COUNTY ADMINISTRATORS, CHILDREN'S MEDICAL SERVICES (CMS) BRANCH STAFF AND REGIONAL OFFICE STAFF

SUBJECT: INTERIM INSTRUCTIONS AND INVOICE FORMS – DIAGNOSTIC, TREATMENT, AND THERAPY EXPENDITURE REPORTING

The CMS Branch is currently updating forms and instructions for the Quarterly Report of Expenditures, Diagnostic, Treatment, and Therapy (DTT) for the CCS Program. Two major changes have occurred since these were last updated. These changes are in the requirements of the interagency regulations with the Department of Education, also known as AB 3632, affecting the Medical Therapy Program, and the CCS Healthy Families (HF) carve out. The revision process will take more time than anticipated. Therefore, the CMS Branch has developed an interim invoice process and interim invoice forms. (Instructions and Forms Enclosed).

The interim invoices have been developed for use until the revised forms are completed. The interim invoice forms enclosed are in Excel and are available via e-mail from the CMS Regional Offices. The interim forms should be used in place of the old forms provided to counties in Numbered Letters 33-1293 and 35-0994; however, the definitions and program requirements outlined in these Numbered Letters still apply. Separate instructions and forms are enclosed for CCS HF reporting and claiming.

The interim invoice forms include fields to enter the amounts of paid claims the county paid to providers directly. **The specific fields for county paid claims may only be used by counties who have made the transition to the State fiscal intermediary for provider claims processing within the last eighteen months of the quarter being claimed and by counties receiving specific written approval from the CMS Branch to pay a provider claim**.

The approval must be on file in the CMS Fiscal Unit, or a copy must be attached to the claim. In the near future, all provider claims will be processed through the FI for payment, and all exceptions will require specific CMS Branch approval.

The interim invoices have specific fields for completion by the county. Other fields on the invoices cannot be changed without the use of a specific password. Totals, subtotals and other calculation fields are shaded. The shaded fields are formula driven to calculate based on the specific data entered by the county. The 'CCS Claim for Reimbursement' worksheet has been developed to calculate the amount due to the State, or due to the County from Part I, Summary of Diagnostic and Treatment worksheet and Part II, Summary of Medical Therapy Program worksheet. The worksheet for HF has fields that must be entered by the county. The HF worksheet will calculate the amount due State or the amount due County based on the data entered. Note there are two HF worksheets to accommodate the different federal fund reimbursement rates established per guidelines of the Federal Medicaid Assistance Program (FMAP). The instructions explain which form to use for the specific quarters reported.

If you have questions, please contact your Regional Administrative Consultant.

Original Signed by Maridee Gregory, M.D.

Maridee A. Gregory, M.D., Chief
Children's Medical Services Branch

Enclosures

Instructions for CCS QUARTELY REPORT OF EXPENDITURES

PART I. SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES

Open the Excel file and go to the worksheet tab labeled 'Part I Dx Trtmnt'. (Enclosure 2)

- Fill in the name of your County on the line at the top left corner.
- Fill in the 'from' date and 'to' date on the 'Expenditures from:' line at the top right corner.

1. DIAGNOSTIC Expenditures

- Enter on line **a** the total amount of Diagnostic expenditures for the quarter from the sum of the three **MR-0-940** reports applicable. **(If the amount is negative, enter as a negative.)**
- Enter on line **b** the total of **County paid diagnostic** expenditures for the quarter. *(Please note, an entry on this line should only be made provided the county has prior approval from the CMS Branch or the transition to the fiscal intermediary (FI) provider payment processing occurred within the last 18 months of the quarter being claimed.)*
- Enter on line **c** the total amount of approved diagnostic expenditure **Adjustments** *(the approved adjustment documentation must be attached).* The amount entered must be entered as **a positive if it is increasing the expenditures** or a **negative if it is decreasing the expenditures**.
- Enter on line **d** the amount of **Miscellaneous Revenue** the county received during the quarter. (this includes deposits made within the county for returned warrants and provider refunds, enter amount as a positive)
- **Lines e and f are formula driven and will calculate based on the data entered in the lines above.**

2. TREATMENT Expenditures

- Enter on line **a** the total amount of Treatment expenditures for the quarter from the sum of the three **MR-0-940** reports applicable. **(If the amount is negative, enter as a negative.)**
- Enter on line **b** the total of **County paid treatment** expenditures for the quarter. *(Please note, an entry on this line should only be made provided the county has prior approval or the transition to FI provider payment processing occurred within the last eighteen months of the quarter being claimed)*
- Enter on line **c** the total amount of approved treatment expenditure **Adjustments** *(the approved adjustment documentation must be attached).* The amount entered must be entered as **a positive if it is increasing the expenditures** or a **negative if it is decreasing the expenditures**.

- Enter on line **d** the amount of **Miscellaneous Revenue** the county received during the quarter. (this includes returned warrants and provider refunds, enter amount as a positive)
- **Lines e and f are formula driven and will calculate based on the data entered in the lines above.**

3. SUBTOTALS DIAGNOSTIC and TREATMENT EXPENDITURES, lines a and b are formula driven and will calculate from the data entered in the lines above. Line **a** represents the total reportable expenditures, and line **b** represents a gross total which is used in determining the amount of reimbursement due to the state or due to the county.

4. TOTAL COUNTY SHARE 50% Net Diagnostic & Treatment Expenditures calculates the **total county share** of the CCS Diagnostic and Treatment Expenditures for the quarter. *This amount is the total reportable county cost of the non Medi-Cal and non Healthy Families CCS diagnostic and treatment expenditures for the quarter. This amount does not necessarily equal the amount of the Claim for Reimbursement which is determined by a number of different variables.*

5. ASSESSMENT FEES, enter in field **'a'** the amount of the year to date outstanding assessment fees and enter in field **'b'** the amount collected for the quarter.

6. ENROLLMENT FEES, enter in field **'a'** the amount of the year to date outstanding enrollment fees and enter in field **'b'** the amount collected for the quarter.

(The remaining lines on this worksheet are formula driven)
7. TOTAL FEES COLLECTED calculates from the entries in 5. and 6.

8. GROSS Diagnostic and Treatment Expenditures, and FEES collected will calculate from the data in the fields '3.b.' and '7.' above.

9. 50% OF GROSS DIAGNOSTIC & TREATMENT, and FEES COLLECTED will calculate from the field on line 8.

10. AMOUNT DUE STATE (positive) or DUE COUNTY (negative) will pull the same amount as line 9 , and is displayed only for summary purposes.

PART II. SUMMARY REPORT OF THERAPY EXPENDITURES

Open the Excel file and go to the worksheet tab labeled 'Part II Therapy'. (Enclosure 3)

The format of this worksheet was updated approximately three years ago to accommodate for claiming the 100% State reimbursable therapy services expenditures per requirements of AB-3632 (Chapter 26.5 Government Code) interagency regulations. In addition, a change in reporting and offsetting reimbursements received for MTP claims submitted to EDS, County Organized Health Systems (COHS), or other plans for Medi-Cal reimbursement has been incorporated in this form. No other claiming requirements or allowable services for the Medical Therapy Program were changed.

Information pertaining to the expenditures claimed for the MTP can be found in the Numbered Letters 33-1293 and 35-0994. Additionally, County programs can find specific detail on the types of equipment and supplies that can be purchased and claimed through their CCS Medical Therapy Program in the numbered letter N.L.: 13-0701, Index: Medical Therapy Program, 'Revised Interagency Agreement...'

Header section: Fill in the caseload fields. Fill in the county name and the 'Expenditures from' and 'to' dates of the quarter.

SECTION I. COUNTY EMPLOYED MEDICAL THERAPY UNIT (MTU) STAFF

The fields (columns/lines) 1 through 9, as applicable, are to be ***completely*** filled in by the county, *(If more space is needed an attachment with the same data requirements must be attached).*

Column entries:

1. **Name (s) of county employed staff**

2. **Classification of the staff** (corresponding to each name).

3. **Monthly Salary of each staff listed**

4. **Full Time Equivalent (FTE) Percent** (Enter in decimals the percent of staff time spent on the therapy program, an employee who is also budgeted on the administrative budget cannot have a total combined FTE percent that exceeds 100 percent).

5. **Expenditures Paid for the Quarter** Multiply the monthly salary (Column 3) for each employee by three (for the three months in the quarter). Multiply the resulting amount by the FTE percent (Column 4) and enter the total in Column 5.

Line 6. **Total Personal Services** Calculate and enter all expenditures identified in Column 5.

Line 7. **Staff Benefits** Enter the percentage paid by the county for staff benefits for county employed therapy personnel in the space provided and Calculate the benefits amount by multiplying the staff benefit percentage by the Total Personal Services amount from Line 6 and enter the total on Line 7.

Line 8. Other Enter an amount ***only*** if your county pays an area differential for recruitment purposes, enter the total amount of the differential paid in the reporting quarter. DO NOT INCLUDE STAFF BENEFITS IN THIS AMOUNT. **Attach a listing to the claim showing the differential paid for the quarter by classification**.

Line 9. Travel Expenses Enter the total amount of travel expenses for all therapy staff incurred during the reporting quarter. *(See Numbered Letters for specific allowable costs)*

Line 10. TOTAL COUNTY STAFF EXPENDITURES will calculate the totals for 'Section I' and 'State Share Due County'.

SECTION II. CONTRACT THERAPISTS

The fields (columns) 1 through 5, are to be ***completely*** filled in by the county if the county contracts for therapy *(if more space is needed, an attachment with the same data requirements must be attached).*

Column entries:

1. **Name(s) of contract staff/company name**

2. **Job Title of contract staff/number of therapists billed.**

3. **Hourly rate paid for each staff listed.**

4. **Number of Hours worked for the quarter.**

5. **Expenditures Paid for the Quarter** Multiply the hourly rate (Column 3) by the corresponding number of hours for each contractor (Column 4) and enter the total in Column 5.

6. **Total Contract Staff Services** Enter on line 6.a. the total of the expenditures from Column 5. The '**State Share Due County**' will calculate one half (1/2) of the amount on Line 6.a.

SECTION III. MTP Coordination… Liaison activities and IEP Attendance

Section III on this claim is specific to the Medical Therapy Program requirements outlined in the Interagency Regulations. The staffing levels are allocated by the state. The personal service expenditures of the staff in this section are reimbursed 100% by the state. This section is to be filled out using the same guidelines used in Section I. for data fields 1 through 9. Line 10 contains formulas to total the lines 6 through 9 and enters the amount 'State Share Due County' 100%.

SECTION IV. OTHER EXPENDITURES

Enter on the appropriate lines (lines 1-3) the type of expenditure claimed. **In addition, attach an itemized listing of the expenditures being claimed.** (***See the Numbered Letters and interagency regulations for the types of expenditures allowed.)*** **Line 4 Total Other** expenditures contains formulas to calculate the total and the 'State Share due County'.

SECTION V. SUBTOTAL This section contains formulas and calculates accordingly.

SECTION VI. ADJUSTMENTS FOR EDS/COHS PAID CLAIMS

Column entries:

1. Enter the sum from **MR-0-940** reports of Therapy Expenditure totals of the three months for the quarter in the space provided.
2. Enter the total amount of reimbursement received from EDS for claims billed to Medi-Cal.
3. Enter the total amount of reimbursement received from County Organized Health Systems (COHS) or other plans.
4. Total EDS/Medi-Cal adjustments field **a.** is a formula and will calculate the sum the lines above and field **b**. Offset to State Share Due County (50%) is a formula and will calculate the amount.

SECTION VII., VIII., and IX. contain formulas and calculates the 'State Share due County' or 'County Share Due State'; and the 'State Share due County 100%'.

SECTION X. Formula calculates the total Therapy expenditures from the county total expenditures (Section V) and the MR-0-940 therapy expenditures (Section VI, line 1.), excluding the 100% state reimbursed county expenditures. This amount is for display and posting purposes only.

Instructions for CCS CLAIM FOR REIMBURSEMENT

Diagnostic / Treatment / Therapy

Open the Excel file and go to the worksheet tab labeled: "Claim for Reimb'. (Enclosure 4)

This worksheet was developed to calculate the amount of reimbursement due the State or due the County from the two separate worksheets, 'Part I DX Trtmnt' and 'Part II Therapy'. The only entries the county will make are as follows:

Heading, the county will enter the county 'name', the 'fiscal year', and the 'from' and 'to' dates for the quarter being claimed.

No other data, or field entries are required before printing, however, the date fields and phone number fields may be entered before printing the form.

Print out the worksheets, review for completeness, and have them signed by the appropriate staff. Send original signed copy of the 'Claim for Reimbursement' and Parts I and II, including required attachments, to:

Children's Medical Services Branch
Program Support Section, Fiscal Unit
MS 8104
P.O. Box 942732
Sacramento, CA 94234-0732

Instructions for 'CCS HEALTHY FAMILIES (HF) QUARTERLY REPORT OF EXPENDITURES'

There are two HF worksheets in the excel file to accommodate for two different federal claiming rates in the state fiscal year (FY). The worksheet labeled 'CCS HF a' (Enclosure 5) is to be used for the first quarter of FY 2002-03 and the worksheet labeled 'CCS HF b' (Enclosure 6) will be used for the second through fourth quarters of FY 2002-03 and all four quarters of FY 2003-04.

Open the Excel file and go to the applicable worksheet tab for HF.

Fill in the 'fiscal year', county 'name', and the 'Expenditures from' and 'to' dates for the quarter being reported.

1. HF TREATMENT

- Enter on line **a.**, the total amount of HF Treatment expenditures for the quarter from the sum of the three **MR-0-940** reports applicable. **(If the amount is negative, enter as a negative.)**
- Enter on line **b.** the total amount of approved HF Treatment expenditure **Adjustments** ***(only adjustments of FI paid claims, MR-0-940 corrections can be entered; approval documentation must be attached)***. The amount entered must be entered as **a positive if it is increasing the expenditures** or **a negative if it is decreasing the expenditures**.
- Enter the amount of County Paid HF Treatment expenditures on line **c.** ***(pre-approval by CMS must be attached or on file in the CMS Fiscal Unit***)
- Line **d.** will calculate the total HF Treatment expenditures.

2. HF THERAPY

*('**HF Therapy**' expenditures are payments to vendors, and are provided in lieu of the County MTP for HF. HF Therapy expenditures should only be coded and paid from this fund source when services have been provided to HF clients.)*

- Enter on line **a.**, the total amount of HF Therapy expenditures for the quarter from the sum of the three **MR-0-940** reports applicable. **(If the amount is negative, enter as a negative.)**

- Enter on line **b.** the total amount of approved HF Therapy expenditure **Adjustments** ***(only adjustments of FI paid claims, MR-0-940 corrections can be entered; approval documentation must be attached)***. The amount entered must be entered as **a positive if it is increasing the expenditures** or **a negative if it is decreasing the expenditures**.
- Enter the amount of County Paid HF Therapy expenditures on line **c.** (***pre-approval by CMS must be attached or on file in the CMS Fiscal Unit***)
- Line **d.** will calculate the total HF Therapy expenditures.

3. TOTAL HEALTHY FAMILIES EXPENDITURES Formula will calculate from the entries made in HF Treatment and HF Therapy. This amount is rounded to the nearest dollar.

4. FUNDING SOURCES The funding sources for **a.** Total HF expenditures and adjustments; **b.** Total County Paid; and **c.** Total HF Expenditure Funding Sources are formula driven.

5. AMOUNT DUE is formula driven and calculates the **Amount due State or Amount due County**

No other data, or field entries are required before printing, however, the date fields and phone number field may be entered before printing the form.

Print out the worksheet, review for completeness, and have it signed by the appropriate staff. Send original signed copy of the '**CCS HEALTHY FAMILIES QUARTERLY REPORT OF EXPENDITURES**' including required attachments, to:

Children's Medical Services Branch
Program Support Section, Fiscal Unit
MS 8104
P.O. Box 942732
Sacramento, CA 94234-0732

CCS QUARTERLY REPORT OF EXPENDITURES

DIAGNOSTIC AND TREATMENT

_____ COUNTY Expenditures from: _____ to: _____

(Per H&S Code, Sections 123800-123995 and related legislation)

PART I SUMMARY REPORT OF DIAGNOSTIC AND TREATMENT EXPENDITURES

1. DIAGNOSTIC Expenditures

a. MR-0-940 $ _____

* b. County paid diagnostic (***requires approval***) _____

c. Adjustments (approval documentation must be attached) _____

State approved adjustments not reported above may be entered by the State during processing. Net and Gross totals may change.

d. Misc. Revenue & Refunds _____

e. Net Diagnostic Expenditures = a + b + c - d **$0**

the 'Net' amount represents total reportable expenditures less revenues & refunds

f. Gross Diagnostic = a - b + c + d **$0**

the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).

* ***transition to EDS was within the last 18 months or approval on file to invoice for county paid claims.***

2. TREATMENT Expenditures

a. MR-0-940 $ _____

* b. County paid treatment (***requires approval***) _____

c. Adjustments (approval documentation must be attached) _____

State approved adjustments not reported above may be entered by the State during processing. Net and Gross totals may change.

d. Misc. Revenue & Refunds $ _____

e. Net Treatment Expenditures = a + b + c - d **$0**

the 'Net' amount represents total reportable expenditures less revenues & refunds.

f. Gross Treatment = a - b + c + d **$0**

the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).

* ***transition to EDS was within the last 18 months or approval on file to invoice for county paid claims.***

3. SUBTOTALS DIAGNOSTIC and TREATMENT EXPENDITURES

a. **Net Diagnostic and Treatment** (1.e. + 2.e.) **$0**

b. **Gross Diagnostic and Treatment** (1.f. + 2.f.) **$0**

4. TOTAL COUNTY SHARE 50% Net Diagnostic & Treatment Expenditures **$0**

(amount reportable as actual County share of expenditures)

5. ASSESSMENT FEES a. receivables _____ **b.collected** _____

6. ENROLLMENT FEES a. receivables _____ **b.collected** _____

7. TOTAL FEES COLLECTED **$0**

8. GROSS Diagnostic and Treatment Expenditures, and Fees collected **$0**

the gross amount represents the amount used to determine what is due the State=positive amount, or due the County= (-).

9. 50% OF GROSS DIAGNOSTIC & TREATMENT, and FEES COLLECTED **$0**

10. AMOUNT DUE STATE (positive) or DUE COUNTY (-) **$0**

AMOUNT DUE may change if any State approved adjustments were entered by the State during processing.

CCS QUARTERLY REPORT OF EXPENDITURES
MEDICAL THERAPY PROGRAM
Part II. Summary Report of Therapy Expenditures

County: _____

Expenditures from _____ to: _____
per Health and Safety Code Sections 123800-123995

MTP Caseload	
non M-C:	
Medi-Cal:	
Total:	0

SECTION I. COUNTY EMPLOYED MTU STAFF (excluding staff designated as MTP liaison and for IEP attendance)

1. NAME	2. CLASSIFICATION	3. MONTHLY SALARY	4. FTE PERCENT	5. EXPENDITURES PAID FOR QUARTER

6. Total Personal Services _____
7. Staff Benefits----------%. _____ _____
8. Other (attach documentation) _____
9. Travel Expenses _____
10. TOTAL COUNTY STAFF EXPENDITURES a. $0 b. State Share Due County (50%) $0

SECTION II. CONTRACT THERAPISTS

1. NAME	2. Job Title	3. HOURLY RATE	4. NUMBER OF HOURS	5. EXPENDITURES PAID FOR QUARTER

6. TOTAL CONTRACT STAFF SERVICES a. _____ b. State Share Due County (50%) $0

SECTION III. MTP COORDINATION with SELPA/LEA -LIAISON ACTIVITIES and IEP ATTENDANCE BY MTP STAFF

1. NAME	2. CLASSIFICATION	3. MONTHLY SALARY	4. FTE PERCENT	5. EXPENDITURES PAID FOR QUARTER

CCS QUARTERLY REPORT OF EXPENDITURES
MEDICAL THERAPY PROGRAM
Part II. Summary Report of Therapy Expenditures

County: _____

Expenditures from _____ to: _____
per Health and Safety Code Sections 123800-123995

6. Total Personal Services				
7. Staff Benefits @ _____%				
8. Other (attach documentation)				
9. Travel Expenses				
10. TOTAL COUNTY STAFF EXPENDITURES	a.	$0	b. State Share Due County (100%)	$0

SECTION IV. OTHER EXPENDITURES (attach documentation)

1. MTU Supply Expenditures				
2. MTU Equipment Expenditures				
3. MTU Conference Expenditures				
4. Total Other Expenditures	a.	$0	b. State Share Due County (50%)	$0

SECTION V. SUBTOTAL -Add SECTIONS I, II, and IV	a.	$0	b.TOTAL State Share Due County (50%	$0

SECTION VI. ADJUSTMENTS for EDS and COHS PAID CLAIMS

1. EDS MR-0-940 reports				
2. EDS Paid Medi-Cal/HFClaims				
3. COHS Paid Claims				
4. Total EDS/COHS Adjustments	a.	$0	b. Offset to State Share Due County (50%)	$0

SECTION VII. TOTAL STATE SHARE AT 50% DUE COUNTY If Section V is greater than Section VI, subtract Section VI from Section V.	State Share Due County	**$0**
SECTION VIII. TOTAL COUNTY SHARE DUE STATE If Section VI is greater than Section V, subtract Section V from SectionVI	County Share Due State	**$0**
SECTION IX. TOTAL STATE SHARE AT 100% DUE COUNTY from SECTION III	State Share Due County (100%)	**$0**
SECTION X. TOTAL THERAPY EXPENDITURES (excludes 100% State rei	**$0**	

CCS CLAIM FOR REIMBURSEMENT
DIAGNOSTIC/TREATMENT/THERAPY

To: STATE OF CALIFORNIA, DEPARTMENT OF HEALTH SERVICES
CLAIM OF: _____ COUNTY **FISCAL YEAR:** _____
FOR EXPENDITURES INCURRED FROM: _____ TO: _____
(PURSUANT TO SECTIONS 123800-123995 OF THE HEALTH AND SAFETY CODE, AND RELATED LEGISLATION)

PART I **DIAGNOSTIC AND TREATMENT** ('*amount from Lines* ' are from the'CCS QUARTERLY REPORT OF EXPENDITURES, PART I')

Positive amount = due State; negative (-)amount = due County. Except line 11&12 display as a positive, the amount due County (line 11) or due

1.	DIAGNOSTIC - (*amount from Line 1. f .*)	$0	
	1.a. County Share (50% of line 1. above)		**$0**
2.	TREATMENT - (*amount from Line 2. f .*)	$0	
	2.a. County Share (50% of line 2. above)		**$0**
3.	Subtotal COUNTY SHARE Diagnostic & Treatment (line 1.a.+ line 2.a.) *positive amount = amount due State, negative (-) amount = amount due County*		**$0**
4.	TOTAL Fees Collected	$0	
	4.a. County Share (50% of line 4. above)		**$0**
5.	**TOTAL PART I (line 3. + line 4.a.)** *positive amount = amount due State, negative (-) amount = amount due County*		**$0**

PART II **MEDICAL THERAPY PROGRAM** (amounts are from CCS QUARTERLY REPORT OF EXPENDITURES, PART II)

6.	Total County Share (*amount from Section VII or Section VIII*)	**$0**
7.	Total 100% Reimbursable to County *(from Section IX, as applicable)*	**$0**
8.	**TOTAL PART II (sum of lines 6, 7, & 8)**	**$0**

PART III **TOTAL CLAIM FOR REIMBURSEMENT**

9.	**TOTAL OF PART I and PART II (Line 5 + Line 8)**	**$0**
10.	**AMOUNT DUE COUNTY**	**$0**
	or	
11.	**AMOUNT DUE STATE**	**$0**

CERTIFICATION:I hereby certify under penalty of perjury, that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or sevices claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previoulsy been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By: _____ Date: _____ Telephone Number : _____

Authorized Signature: _____ Title: _____ Date: _____

State of California - Health and Human Services Agency *Department of Health Services*

CCS HEALTHY FAMILIES (HF) QUARTERLY REPORT OF EXPENDITURES

FISCAL YEAR: _____

_____ COUNTY Expenditures from: _____ to: _____

(Per H&S Code, Sections 123800-123995 and related legislation)

1. HF TREATMENT

a. MR-0-940	$ _____	
* b.Treatment Adjustments *(fiscal intermediary related, MR-0-940 only)*	_____	
c. County Paid HF Treatment	_____	
d. Total HF Treatment (a. + b. + c.)		**$0**

**** Approval documentation must be attached, or on file with CMS fiscal unit. Approved adjustments, not reported above, may be entered by the State during processing which may change the totals.***

2. HF THERAPY

a. MR-0-940	$ _____	
* b. Therapy Adjustments *(fiscal intermediary related, MR-0-940 only)*	_____	
c. County Paid HF Therapy	_____	
d. Total HF Therapy (a.+ b.+c.)		**$0**

**** Adjustments of FI paid claims only, documentation must be attached, or on file with CMS fiscal unit. Approved adjustments, not reported above, may be entered by the State during processing which may change the totals.***

3. TOTAL HEALTHY FAMILIES EXPENDITURES *(Total is rounded to nearest dollar)* **$0**

4. FUNDING SOURCES

	Federal Title XXI	State	County
a. Total MR-0-940 and Adjustments	$0	$0	$0
b. Total County Paid	$0	$0	$0
c. Total HF Expenditure Funding Sources	$0	$0	$0

5. AMOUNT DUE (formula will calculate) :

Amount due STATE	$0
or	
Amount due COUNTY	$0

CERTIFICATION:I hereby certify under penalty of perjury, that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or sevices claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previoulsy been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By: _____ Date: _____ Telephone Number : _____

Authorized Signature _____ Title: _____ Date: _____

CCS HEALTHY FAMILIES (HF) QUARTERLY REPORT OF EXPENDITURES

FISCAL YEAR: _____

_____ COUNTY Expenditures from: _____ to: _____

(Per H&S Code, Sections 123800-123995 and related legislation)

1. HF TREATMENT

a. MR-0-940	$ _____	
* b.Treatment Adjustments *(fiscal intermediary related, MR-0-940 only)*	_____	
c. County Paid HF Treatment	_____	
d. Total HF Treatment (a. + b. + c.)		**$0**

**** Approval documentation must be attached, or on file with CMS fiscal unit. Approved adjustments, not reported above, may be entered by the State during processing which may change the totals.***

2. HF THERAPY

a. MR-0-940	$ _____	
* b. Therapy Adjustments *(fiscal intermediary related, MR-0-940 only)*	_____	
c. County Paid HF Therapy	_____	
d. Total HF Therapy (a.+ b.+c.)		**$0**

**** Adjustments of FI paid claims only, documentation must be attached, or on file with CMS fiscal unit. Approved adjustments, not reported above, may be entered by the State during processing which may change the totals.***

3. TOTAL HEALTHY FAMILIES EXPENDITURES *(Total is rounded to nearest dollar)* **$0**

4. FUNDING SOURCES

	Federal Title XXI	State	County
a. Total MR-0-940 and Adjustments	**$0**	**$0**	**$0**
b. Total County Paid	**$0**	**$0**	**$0**
c. Total HF Expenditure Funding Sources	**$0**	**$0**	**$0**

5. AMOUNT DUE (formula will calculate) :

Amount due STATE	**$0**
or	
Amount due COUNTY	**$0**

CERTIFICATION:I hereby certify under penalty of perjury, that I am the duly authorized officer of the claimant herein and this claim is in all respects true, correct, and in accordance with the law; that the materials, supplies, or sevices claimed have been received or performed and were used or performed exclusively in connection with the program; that I have not violated any of the provisions of Section 1090 to 1096 of the Government Code in incurring the items of expense included in this claim; that prior to the end of the quarter for which the claim is submitted, warrants have been issued in payment of all expenditures included in this claim; that payment has not previoulsy been received for the amount claimed herein; and that the original invoices, payrolls, and other vouchers in support of this claim are on file with the county.

Prepared By: _____ Date: _____ Telephone Number : _____

Authorized Signature _____ Title: _____ Date: _____